IRWIN PHYSIOTHERAPY

Patient Information Form

Name: _____ Date: _____
First Name Initial Last Name

Date of Birth (D/M/Y): ____/____/____ Gender: Female Male Other Pronouns: _____

Marital Status: single married/common law widowed divorced

Home Mailing Address:
Street: _____ Box #: _____
Town: _____ Postal Code: _____
Home Phone Number: _____ Cell: _____
Email Address: _____
Consent to receive appointment reminders via email: _____
(Signature)

Occupation: _____
Employer: _____
Phone Number: _____

Do you have **Extended Health Benefits? Yes ☐ No ☐**
Company *(Sun Life / GreenShield etc.):* _____
Policy Number: _____
Claim / ID Number: _____
Insured Members Name (if different than patient): _____ Date of Birth: _____

Is this a **Worker's Compensation Claim (WSIB)?: Yes ☐ No ☐**
Date of Injury / Accident (D/M/Y): ___/___/___ Claim Number: _____
Name of WSIB Adjustor / Nurse Case Manager (if known): _____
Employer Contact Name: _____
Employer Address: _____

Is your injury due to a **Motor Vehicle Accident? Yes ☐ No ☐**
Automobile Insurance Company: _____
Date of Accident (D/M/Y): ____/____/____ Claim Number: _____
Policy Number: _____ Policy Holder: Self ☐ Other: ☐_____
Adjuster Name: _____
Adjuster Phone #: _____ Fax #: _____

Who referred you for Physiotherapy? _____

Family Physician: _____
Address: _____
Phone Number: _____

Surgeon's Name: _____ (if applicable)

CURRENT MEDICAL CONDITIONS:
Reason for consulting this office?

_____

What are your treatment goals or expectations from physiotherapy treatment?

_____

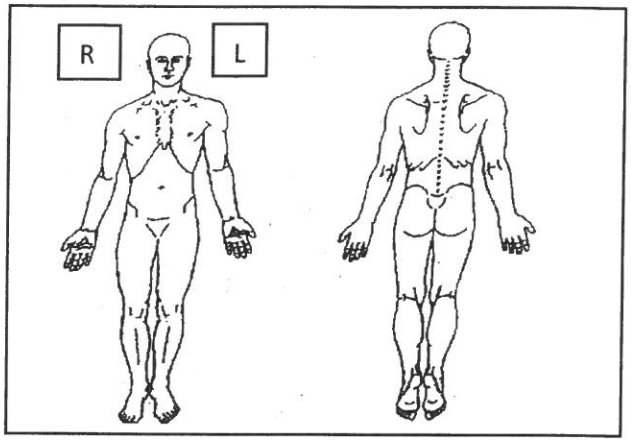
Are you currently pregnant or do you suspect you might be pregnant? Yes ☐ No ☐

Do you have a Pace Maker: YES ☐ NO ☐

PAIN DIAGRAM:

Please indicate on the diagrams (using the appropriate symbols) the area(s) of pain or unusual feelings.

Numbness: +++++
Pins and Needles: ******
Burning: xxxxxxx
Aching: /////////
Stabbing: oooooo



MEDICATIONS:
Please list any medications you are currently taking (including birth control, aspirin, medical marijuana)

_____

_____

PAST MEDICAL HISTORY:
Please check (✓) any condition that you have had in the past and circle any that are of present concern.

Aneurysm
Osteoporosis/osteopenia
If yes:
Most recent bone scan date: _____
T-score from bone scan: _____

Osteoarthritis
Stroke
Polio
Asthma
Rheumatoid arthritis

Hepatitis: A ☐ B ☐ C ☐

Diabetes: Type 1 ☐ Type 2 ☐

Cancer: type _____
If yes, date of latest follow –up:
_____

Thyroid Condition: ☐
- Hyperthyroidism
- Hypothyroidism ☐

Heart Attacks: Date?
_____

Other: _____
_____

Are you presently or have you taken any of the following for a prolonged period of time in the past?

Prednisone
Coumadin
Methotrexate

Amitriptyline
Warfarin
Thyrox

If yes to any of the above:
Duration of Use: _____

Date of last dose: _____

PHYSIOTHERAPY PAYMENT POLICY

Thank you for choosing Irwin Physiotherapy as your treatment facility. It is necessary that you be advised of and that you agree to the payment policy for our services before you begin treatment.

PAYMENT SOURCES:

Payment for physiotherapy services generally comes from the following sources:

- Extended Health Plans
- Motor Vehicle Insurance
- The Workplace Safety and Insurance Board (WSIB)
- Disability Insurance Plans
- Bundled Care Program
- Direct payment from the employer
- Direct payment from the patient
- **Note: Physiotherapy treatments in this facility are NOT covered under the Ontario Health Insurance Plan (OHIP).**

FEES:

For private pay or extended health patients the fees are:

Initial Assessment and Report: $100.00 / Initial Assessment including Impact Test for Concussions: $130.00
Subsequent Treatments: $60.00
Impact Test $50.00 for each additional test

WSIB and MVA fees are set by the respective institutions.

PAYMENT FREQUENCY:

For treatment that cannot be billed directly from this office, **payment is due at the end of each treatment session**.

PATIENT RESPONSIBILITIES

If these requirements are not fulfilled and a claim is denied, you will be responsible for payment of all services.

Customized Orthotics:

We require a $175 deposit before ordering your customized orthotics. This deposit will go towards the final price of the orthotics once they have been delivered to the clinic.

Extended Health Insurance:

Please review your plan to ensure you have full understanding of the amount and type of coverage your plan offers. A physician's referral is *sometimes* required by the insurer before they will provide reimbursement.

Workplace Safety and Insurance Board (WSIB):

If you are submitting a claim through WSIB it is your responsibility to:

- ensure your employer and physician have completed and submitted all the necessary claim forms
- attend regular appointments with your physician as required by WSIB
- Complete all reports and forms (e.g. Injured Worker Progress Notes and Physician Progress Note) that are requested by WSIB in a timely manner

Motor Vehicle Accident (MVA) Insurance:

If you are submitting a claim through your motor vehicle insurance company it is your responsibility to:

- complete and submit all the necessary paperwork in the ***Accident Benefits (AB) Package*** that is supplied by your insurance company
- provide the clinic with extended health insurance claim forms (as requested by the clinic)
- deliver any cheques that are received from your extended health insurance company that are for physiotherapy services performed and billed by Irwin Physiotherapy
- Provide Irwin Physiotherapy with a copy of the *Explanation of Benefits* that accompanies the payment from your extended health insurance company.

NO SHOW POLICY

- We request reasonable notice for any cancelled appointments
- **A fee of $40.00 will be applied to your account for missed appointments**. A missed appointment is when no attempt is made by the patient to cancel the appointment before the scheduled appointment time
- 3 missed appointments will result in the patient discharge with no warning

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I have read the above information and have a full understanding and agree to the above payment policies.

PATIENT SIGNATURE _____ **DATE** _____

Irwin Physiotherapy Privacy Policy

We value your business and thank you for your confidence in choosing our clinic as your Physiotherapy provider. You trust us with your personal information. We respect that trust and want you to be aware of our commitment to protect the information you share in the course of doing business with us.

How We Collect, Use and Disclose Your Information

When you attend for assessment or treatment from us, you share personal information so that we may provide you with products and services that best meet your needs. We assume your consent for our clinic to use this information in an appropriate manner. We may use and disclose this information in order to:

1) Ensure the assessing and treating practitioners can provide excellence in service provision by accessing all appropriate information when needed along a continuum of care.
2) Collect sufficient information to ensure that the service(s) provided will be paid for by the appropriate body(ies).
3) To advise clients, via email, of future appointment notifications
4) To advise clients and others of special events (e.g. a seminar, development of a new service, arrival of a new product).
5) Our clinic reviews client and other files for the purpose of ensuring that we provide high quality services, including assessing the performance of our staff.
6) All our Physiotherapists are regulated by the College of Physiotherapists of Ontario, who may inspect our records and interview our staff as a part of their regulatory activities in the public interest.

We Strive to Protect Your Personal Information

All employees and consultants who are granted access to customer records understand the need to keep this information protected and confidential. They know they are to use the information only for the purposes intended. This expectation is clearly communicated and violation of this trust will result in immediate termination of the service. We've also established physical and systems safeguards, along with the proper processes, to protect customer information from unauthorized access or use.

Your Privacy Choices

You may withdraw your implied consent at any time (subject to legal or contractual obligation and on providing us reasonable notice) by contacting our Privacy Officer. Please be aware that withdrawing your consent may prevent us from providing you with the requested product or service.

If You Need More Information

For more information about our privacy policies and procedures, please contact Irwin Physiotherapy's
Health Information Custodian (Craig Irwin) at 519-527-1551.

IRWIN PHYSIOTHERAPY

IRWIN PHYSIOTHERAPY INFORMED CONSENT FORM

CONSENT FOR TREATMENT **Patient Initials:**_____

I, _____ hereby consent to assessment and treatment, including various physical modalities, manual therapy and an active exercise program.

I further understand and am informed that, as in all health care, there are some slight risks to treatment, including but not limited to, muscle strain, sprains, muscle soreness, disc injuries and strokes. I wish to rely on the physiotherapist to exercise judgment during the course of my rehabilitation which the physiotherapist feels, based upon the facts then known, is in my best interest.

I understand that any consent to treatment or to a portion of the proposed treatment plan can be voluntarily withdrawn without ramification.

CONSENT FOR PERSONAL INFORMATION **Patient Initials:**_____

I understand that to provide me with physiotherapy treatment, Irwin Physiotherapy will collect some personal information about me. This includes home and work telephone number, address, date of birth, and if applicable, WSIB claim number, Extended Health Benefits information, Casualty or LTD Insurance information.

I have been provided the opportunity to review Irwin Physiotherapy's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions about the Privacy Policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Irwin Physiotherapy collecting, using and disclosing personal information about me as set out above and in the Privacy Policy.

CONSENT TO ALLOW USE OF SUPPORT PERSONNEL Patient Initials: _____

I understand that to provide me with physiotherapy treatment, Irwin Physiotherapy utilizes support staff to provide me exercise instruction and administer ultrasound/IFC/heat to my affected areas.

Nicole Laprise, PTA is the support staff that assists with the provision of physiotherapy services at Irwin Physiotherapy. Nicole Laprise, PTA is trained in the application of therapeutic modalities and therapeutic exercises. Provision of this treatment is at the direction of and is supervised by Craig Irwin, PT / Kate Cronin, PT / Pat Morris, PT.

I understand that any consent for use of support personnel can be voluntarily withdrawn without ramifications at any time during the treatment plan.

_____ _____

Patient Name (Please Print) **Date:**

_____ _____

Patient Signature
Or Parent /Guardian Signature
(if patient is less than 16 years of age)

Signature of Witness:

TELUS Health

Electronic transmission authorization and consent form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider		
First and last name or clinic name **Irwin Physiotherapy - Craig Irwin/Kate Cronin/Pat Morris**		
Address **100 Main Street South, P.O. Box 698**		
City **Seaforth**	Province **ON**	Postal code **N0K 1W0**

Patient	
First name	Last name
Primary coverage insurer/payer	Primary coverage plan member name
Primary coverage policy number (also referred to as group or contract number)	
Primary coverage certificate (also referred to as member/identification number)	
(Canada Life only) secondary coverage plan member name	

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

Authorization and consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize such insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

☐ **I accept the terms and conditions**

Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the healthcare provider.

☐ **I accept the terms and conditions**

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.